APPLICATION TO PROVIDE PERSONAL CARE II SERVICES

The Community Long Term Care (CLTC) Program contracts with qualified providers to provide Personal Care II services to Medicaid recipients. These services are prior authorized by CLTC case managers and nurses. The authorization includes the number of hours of service per week, the days the service is to be provided, the hours each day and the time of day the service should be provided (morning, afternoon or evening). Contracting as a provider of Personal Care II services allows the provider to serve the following groups:

- Community Choices Waiver Participants;
- HIV/AIDS Waiver Participants;
- Mechanical Ventilation Waiver Participants;
- South Carolina Choice Waiver Participants;
- Children receiving Personal Care services.

In addition, providers may provide services to participants in two waivers that the Department of Disabilities and Special Needs (DDSN) oversees:

- Mental Retardation/Related Disabilities Waiver Participants;
- Head and Spinal Cord Injury Waiver Participants.

For these two waiver programs, DDSN will authorize services. For the Head and Spinal Cord Injury (HASCI) Waiver the services that may be authorized include Attendant Care and In home respite service.

Any provider qualifying to provide Personal Care II services may also contract to provide Personal Care I, HASCI Attendant Care, HASCI in-home respite care and Companion services. The application form allows you to indicate if you wish to also provide those services.

Hourly reimbursement rates are as indicated below:

- Personal Care II: $16.00
- HASCI Attendant: $16.00
- HASCI Hourly Respite: $7.75
- HASCI Daily Respite: $62.00
- Personal Care I: $12.00
- Agency Companion: $9.00

Providers must follow the Scopes of Services for each of these services, as well as meeting all other contractual obligations. The Scope of Services can be found on this web site. You should print a copy to review before completing this application.

Each client is required to choose a provider from a CLIENT CHOICE OF PROVIDER FORM that lists all CLTC providers in the area by county. Because of the client choice of provider policy we cannot guarantee the number of CLTC clients any provider will be authorized to serve. Therefore, we urge all providers not to rely upon Medicaid as the primary source for reimbursement. **Business decisions should not be made based on any agency's or individual's anticipation of receiving any referrals from CLTC**.

In order to complete an application, print this document. Check the appropriate boxes and fill in the information that is requested. You must also include the items listed in addition to completing this application.

Applications should be sent to: **Division of Community Long Term Care- Waiver Management, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Chaini Demas**. If you have any questions regarding this process or the stated requirements, please call Chaini Demas at (803) 898-2709 or Tony Matthews at (803) 898-2712.

The following items must be checked and/or enclosed for this application to be considered for processing:

I wish to become a provider of the following services: (Check all for which you are applying)

- ❑ Personal Care II (PCII)
- ❑ Personal Care I (PCI)
- ❑ Agency Companion
- ❑ HASCI Attendant Care
- ❑ HASCI In Home Respite

❑ I understand that It will be necessary to schedule a South Carolina Department of Health and Human Services (SCDHHS) compliance review visit as part of the contracting process and that I will be contacted prior to this visit.

❑ I agree to abide by all requirements and policies of the SCDHHS as described in my contract and any other communication received from SCDHHS.

❑ I certify that neither I, nor any officer, director, administrator, billing agent, managing employee, affiliated person or partner, or shareholder having an ownership interest has been involuntarily terminated or has involuntarily withdrawn from participation in the CLTC Program within the last three (3) years.

❑ By checking this box I am indicating that my agency requires Medicaid participants to sign agreements. (Leave blank if this is not the case.) I understand that I must include copies of all agreements with this provider application.

❑ I certify that this agency will submit any subcontracts to SCDHHS for prior approval.

❑ I certify that a governing body or person(s) so functioning shall assume full legal authority for the operation of the provider agency.

❑ My regularly scheduled holidays are listed on the attached sheet.

❑ The county or counties in which my agency plans to provide services are listed on the attached sheet:

❑ I understand that this agency may be reviewed by SCDHHS at any time during normal business hours. This review can be announced or unannounced. I also understand that my agency must produce all requested records related to the administration of the agency, staff records and individual client records.

❑ I understand that persons providing in-home services and nurse supervisors must use the Care Call system to document their service delivery and adherence to this contract.

❑ I understand that I must abide by all marketing limitations as indicated in the contract.

❑ I understand that I must not give any type of gifts, samples or other products to CLTC case managers or other CLTC employees.

❑ I understand that my staff must report incidents of abuse, neglect or exploitation of adult beneficiaries in accordance with the Omnibus Adult Protection Act (S.C. Code of Laws Section 43-35-5, et seq.).

❑ I understand that I will be required to attend a training session at SCDHHS prior to the initiation of a contract.

The name of the person who will sign the contract: _____

The name of the person designated to serve as the agency administrator: _____

The following items must be submitted with your application:

- You must submit certified evidence of not less than $10,000.00 operating capital that will show that the provider agency has the capability to operate for a minimum of 60 days in the event Medicaid reimbursement is delayed or withheld for any reason. This must be a written statement from an officer of a financial institution or a certified accountant; a copy of your most recent bank statement must be included.

- Documentation that demonstrates experience, i.e., written references, established agency verification, etc., in providing Personal Care II or a similar service.

- A copy of your organizational chart that includes the names of persons in any management or ownership capacity. (See attached form)

- A copy of the provider agency's Workers' Compensation Insurance Policy. If you do not yet have one, please indicate on your application. A copy of the policy must be presented prior to the provision of services.

- A copy or letter of certification of the provider agency's current liability insurance Policy showing coverage to include date of application.

- A copy of your articles of incorporation or other document that established you as a legal entity. If you do not already have this, it must be obtained from the Secretary of State. If you are a Sole Proprietor, this is not required. Sole Proprietors must provide a copy of your business license.

- A copy of your Employer Identification Number (EIN) confirmation letter.

- Copies of current licenses of all Nurse Supervisors.

- A completed Pre-contractual Information Form. (See attached form)

The following items must be brought to your scheduled training session:

- Your company's policy and procedure manual
- Infectious disease program
- Your company back-up plan
- In-service program – should include topics that will be used for in-service hours
- Mock employee and participant chart

I certify that all information given with this application is true. I understand that any false information will result in this application being denied.

_____
Applicant's Name Printed

_____ _____ _____
Applicant's signature **Title** **Date**

Agency Telephone Number_____

Agency Fax Number_____

Alternate Telephone/Cell Number_____

Agency Name_____

Agency address_____

_____

_____

Mailing address if different from Agency address:

_____

_____

Email address: _____

List of Scheduled Holidays

Check each holiday observed by your agency and indicate additional holidays below.

- ❑ New Year's Day
- ❑ Martin Luther King's Birthday
- ❑ Presidents Day
- ❑ Good Friday
- ❑ Easter
- ❑ Memorial Day
- ❑ Independence Day (July 4th or day observed)
- ❑ Labor Day
- ❑ Veterans Day
- ❑ Thanksgiving
- ❑ Day after Thanksgiving
- ❑ Christmas Eve
- ❑ Christmas
- ❑ Day after Christmas

List additional holidays here:

_____

_____

Counties Served

Put a check next to every county in which you intend to provide services. Remember that you must be able to demonstrate that you have a nurse close enough to the county to meet the geographical scope requirements.

- ☐ Abbeville
- ☐ Aiken
- ☐ Allendale
- ☐ Anderson
- ☐ Bamberg
- ☐ Barnwell
- ☐ Beaufort
- ☐ Berkeley
- ☐ Calhoun
- ☐ Charleston
- ☐ Cherokee
- ☐ Chester
- ☐ Chesterfield
- ☐ Clarendon
- ☐ Colleton
- ☐ Darlington
- ☐ Dillon
- ☐ Dorchester
- ☐ Edgefield
- ☐ Fairfield
- ☐ Florence
- ☐ Georgetown
- ☐ Greenville
- ☐ Greenwood
- ☐ Hampton
- ☐ Horry
- ☐ Jasper
- ☐ Kershaw
- ☐ Lancaster
- ☐ Laurens
- ☐ Lee
- ☐ Lexington
- ☐ McCormick
- ☐ Marion
- ☐ Marlboro
- ☐ Newberry
- ☐ Oconee
- ☐ Orangeburg
- ☐ Pickens
- ☐ Richland
- ☐ Saluda
- ☐ Spartanburg
- ☐ Sumter
- ☐ Union
- ☐ Williamsburg
- ☐ York
- ☐ Statewide

Pre-Contractual Information Form

Have you ever worked for an agency that has received Medicaid funds? _____

If yes, what agency and what was your position? _____

Have you have ever been an enrolled or contracted Medicaid provider?
If yes, when (dates)_____ Which state? _____ What service did you provide?_____
What was/is your previous/current Medicaid provider number?_____
Are you currently enrolled or contracted with DHHS for any service provision? _____
If not, when did contract or enrollment end?_____
If terminated, was termination voluntary or involuntary?_____
If this is an agency or corporate entity, has the agency ever been enrolled or contracted with Medicaid? If yes, when? (dates)_____ Which state?_____
What type of service was provided? _____

What was/is the agency's or corporate entity's previous/current Medicaid provider number?_____

Have any officers, agents or employees been terminated, been denied participation in the Medicaid Program or denied a contract with DHHS?_____
If yes, when? (dates) _____ For what service? _____
Reason?

Any falsification of information submitted is grounds for denial or termination of a contract.

_____ _____
Signature Date

SAMPLE ORGANIZATIONAL CHART

President

Name:_____

Chief Executive Officer

Name:_____

Chief Financial Officer

Name:_____

Chief Operations Officer

Name:_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

Supervisor

Name:
_____

*This chart is only a sample and may not apply to the organizational structure of your company. You may utilize this chart or create your own that more closely represents the organizational structure of your company.